from lead weights resulted in nerve damage and thigh numbness. No similar cases have been recorded. Scuba diving is a common diversion and occupation. Some of the many participants could be at risk for a compression neuropathy from the above-described mechanism. We propose the term "scuba diver's thigh" as descriptive of this entity and as a means of publicizing an uncomfortable and preventable hazard.

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More on BHT Toxicity

To the Editor: Apropos Dr Grogan's case report of butylated hydroxytoluene (BHT) neurotoxicity,[1] earlier this year we published a case report in *The New England Journal of Medicine* of BHT gastritis.[2] After reading Pearson and Shaw's best-selling book, *The Life Extension Companion*,[3] our patient, who suffered from recurrent genital herpes, ingested 4 grams of BHT on an empty stomach. Within several hours she was experiencing severe epigastric cramping, generalized weakness, nausea and vomiting, and within 48 hours became dehydrated enough to require admission to hospital. Particularly interesting were the concomitant neurologic symptoms of dizziness, confusion and a brief loss of consciousness similar to those noted in Dr Grogan's case report.

Since publication of our letter to the editor, we have had numerous written communications with clinicians both in and outside the United States concerned with the potential toxic effects of BHT in their patients.

Claims of BHT's efficacy for the treatment of herpes simplex in humans are unsubstantiated. Likewise, no well-controlled clinical trials have been done to determine safe dosages in humans despite serious side effects reported in laboratory animals even with comparatively low-dose regimens.[4,5]

The fact that patients waste millions of dollars yearly on ineffective herpes treatments is unfortunate. The fact that some of these "treatments" are potentially toxic is particularly disturbing.

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Treatment for Impotence

To the Editor: Over the past ten years there has been a heightened awareness of the problem of impotence. We appreciated the review of the evaluation of impotence by Dr Cooke in the July issue.[1] However, as an endocrinologist and a clinical psychologist who have seen a large number of patients with impotence, particularly men with diabetes, we would like to offer some suggestions which we have found valuable in our program.

We have found that psychogenic impotence is often very difficult to distinguish from organic causes. Following a complete medical evaluation and appropriate laboratory and hormonal tests, patients should have a psychological assessment by a psychologist or psychiatrist who has a special interest and expertise in diagnosis and treatment of male sexual dysfunctions. We find that a multidisciplinary approach brings us greater success in treating cases of mixed cause. Use of a new ambulatory device called the RigiScan, which allows both the detection of nocturnal tumescence and the simultaneous measurements of rigidity, has helped us in the differential diagnosis of organic versus psychogenic impotence.[2] The documentation of normal erectile function during sleep in impotent men can serve as a biofeedback technique to demonstrate the integrity of their own erectile apparatus.

It should also be pointed out that sexual function may be preserved in mild hypogonadism, may not be corrected with testosterone replacement alone and further diagnostic studies may be needed. Impotence associated with diabetes[3] or antihypertensive drugs may be psychogenic and should not necessarily be ascribed to these organic causes without a comprehensive diagnostic workup. Dr Cooke did not make any mention of the use of the Erectaid,[4] a vacuum device that produces a mechanical erection, nor did she mention the long-term use of intracorporeal papaverine hydrochloride[5] or phentolamine mesylate[6] (or both) in selected patients with erectile failure.

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Unfounded Criticisms of Physicians

To the Editor: As you might expect, Mr Pollock's article "Cut the Cost, Keep the Care" in the August issue[1] riled me more than a little, as it must have many other physicians. To "put doctors on a similar diet" of cost controls infers that we have not already contributed to our share of the challenge of caring for the elderly and the poor. Who is Mr Pollock, or the AARP for that matter, to lump us all together in such a cate-